

must provide a copy of the acceptance letter showing that you are a participant in SSI or a member of a family/economic unit participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or on a waiting list for WIC. A copy of your Tribal ID will be needed, as well as proof of residency, a copy of your driver's license, State ID, or household bill in your name.

PROXY

A proxy is a person only authorized to receive and/or redeem SFMNP coupons. A proxy should be at least 18 years of age and dependable for the duration of the program months of operation. For the coupons to be issued to a proxy, the proxy must present identification as well as written approval from the participant. Proxies must sign a designated line on the coupon log sheet before receiving the coupons. Proxies have the same obligations to follow program guidelines when purchasing fruits and vegetables from an authorized farmer.

I, _____ authorize the following individual(s) to act as my proxy.
Participant signature

Assigned proxies: _____
1st proxy named _____ 2nd proxy names _____

____ Check here if no proxy was assigned.

CERTIFICATION BY PARTICIPANT

I have been advised of my rights and obligations under the SFMNP. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge. I am aware that I cannot receive farmers' market benefits from more than one state, more than one local agency or program model (check, coupon or CSA). This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. Standards for eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, age, disability or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. I certify I meet the 2024/25 household size and income guidelines provided by the state and that I am eligible to receive SFMNP benefits.

Signature of Participant Date

Signature of Certifier Date

Issued SFMNP booklet # _____ thru _____ Date _____

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating based on race, color, national origin, sex, age, and disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."